
March 1998

MEDICAID

Demographics of Nonenrolled Children Suggest State Outreach Strategies





**United States
General Accounting Office
Washington, D.C. 20548**

**Health, Education, and
Human Services Division**

B-278558

March 20, 1998

The Honorable John McCain
United States Senate

Dear Senator McCain:

Health insurance has become increasingly important as a means for providing children access to adequate health care, yet in 1996, 10.6 million children were uninsured. The Congress recently demonstrated its interest in insuring more children by committing more than \$20 billion over a 5-year period to fund state expansions of children's health insurance—either through the Medicaid program or through insurance programs developed by states. However, as we have reported in the past, many uninsured children who are eligible for Medicaid are not enrolled.¹

Concerned about this failure to enroll children in Medicaid, you asked us to

- examine the demographic and socioeconomic characteristics of children who qualify for Medicaid, and identify groups in which uninsured children are concentrated and to whom outreach efforts might be targeted;
- determine the reasons these children are not enrolled in Medicaid; and
- identify strategies that states and communities are using to increase enrollment.

To examine the characteristics of families of Medicaid-eligible uninsured children, we analyzed data from the Bureau of the Census' March 1997 Current Population Survey (CPS). To develop a demographic profile of uninsured Medicaid-eligible children, we linked information on children's health insurance status with their families' characteristics and compared them with children similar in age and family income who are enrolled in Medicaid or who have employment-based insurance. In this analysis, we only considered children who met the federal age and income standards for mandated eligibility. We did not include children who could be eligible because of individual state expansions or children over age 12 who could be eligible if their family income was low enough to receive cash assistance in their state.

¹Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate (GAO/HEHS-96-129, June 17, 1996); Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175, July 19, 1995).

To determine the reasons eligible children are not enrolled in Medicaid and identify strategies that could assist in getting such children enrolled, we interviewed state officials, beneficiary advocates, and provider representatives in Arkansas and Massachusetts; state officials in Georgia; and other experts. We also reviewed the outreach materials used by these states and by Wisconsin. Arkansas, Georgia, and Massachusetts were selected from among several states that were identified by experts as having innovative outreach programs. Additionally, Wisconsin was identified as being further along in its approach to welfare reform and Medicaid outreach and eligibility determination. State outreach programs are designed to reach all Medicaid eligibles, and the programs we reviewed target all eligible children, both mandated and optional. For more information on our scope and methodology, see appendix I. Our work was conducted between July 1997 and February 1998, in accordance with generally accepted government auditing standards.

Results in Brief

The demographic and socioeconomic characteristics of uninsured Medicaid-eligible children suggest that outreach strategies could be targeted to specific groups. In 1996, 3.4 million Medicaid-eligible children—23 percent of those eligible under the federal mandate—were uninsured. The majority were children of working poor or near poor, and their parents were often employed by small firms and were themselves uninsured. Uninsured children who are eligible for Medicaid are more likely to be in working families, Hispanic, and either U.S.-born to foreign-born parents or foreign-born. This suggests that state outreach may effectively target working families and qualified immigrants. States in the West have higher numbers and percentages of Hispanics and immigrants among their Medicaid-eligible uninsured children, suggesting that these groups could also be targeted. Because nearly three-quarters of uninsured Medicaid-eligible children live in the West and the South, states in these regions may already face greater challenges in enrolling eligible children than other states.

State officials, beneficiary advocates, and health care providers whom we contacted cited several reasons that families do not enroll their children in Medicaid. Lower income working families may not realize that their children qualify for Medicaid, or they may think their children do not need coverage if they are not currently sick. Under welfare reform, the delinking of Medicaid and cash assistance may cause some confusion for families, although in a recent report, we found that states were making efforts to retain a single application and eligibility determination process

to avoid this problem. In addition, many low-income families believe that Medicaid carries the same negative image of dependency and inability to provide for their family that they attach to welfare. Immigrant families, many of whom are Hispanic, face additional barriers, including language and cultural separateness, fear of dealing with the government, and changing eligibility rules. Finally, the enrollment process for Medicaid can involve long forms and extensive documentation, which are intended to ensure program integrity but often are a major deterrent to enrollment.

Recognizing these impediments, some states have undertaken education and outreach initiatives and have tried to change the image of the program and simplify enrollment to acquire only information deemed essential. For example, Arkansas and Massachusetts recently initiated major outreach efforts to publicize their expansions of coverage for children and to reach families who are unaware of their children's eligibility. These efforts include mass media campaigns and coordination of effort with community organizations and provider groups. Part of their campaign is to inform the public that Medicaid is available for children in working families. Some states have made their application and enrollment process more accessible for working families, using mail-in applications or enrollment at sites chosen for their convenience. In Georgia, for example, the state has over 140 outreach workers located at nontraditional sites, such as supermarkets, who often work evening and weekend hours. To minimize its identification with welfare and other assistance programs, several states have changed the name of their Medicaid program. To facilitate enrollment of Hispanics, many states provide Spanish-language applications and some are working with community groups. Some states have also simplified enrollment procedures by shortening the enrollment form and reducing the documentation requirements. Of states whose outreach programs we reviewed, officials and advocates emphasized the importance of consensus and support from a broad spectrum of political and community leaders in gaining visibility and resources for outreach.

Background

Studies have shown that insured children are more likely than uninsured children to get preventive and primary health care.² Insured children are also more likely to have a relationship with a primary care physician and to receive required preventive services, such as well-child checkups. In contrast, lack of insurance can inhibit parents from trying to get health care for their children and can lead providers to offer less intensive

²Health Insurance: Coverage Leads to Increased Health Care Access for Children (GAO/HEHS-98-14, Nov. 24, 1997).

services when families seek care. Several studies have found that low-income and uninsured children are more likely to be hospitalized for conditions that could have been managed with appropriate outpatient care.³

Most insured U.S. children under age 18 have health coverage through their parents' employment—62 percent in 1996. Most other children with insurance have publicly funded coverage, usually the Medicaid program. Medicaid—a jointly funded federal-state entitlement program that provides health coverage for both children and adults—is administered through 56 separate programs, including the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. Historically, children and their parents were automatically covered if they received benefits under the Aid to Families With Dependent Children (AFDC) program. Children and adults may also be eligible for Medicaid if they are disabled and have low incomes or, at state discretion, if their medical expenses are extremely high relative to family income.

Before 1989, coverage expansions for pregnant women and children based on family income and age were optional for states, although many states had expanded coverage. Starting in July 1989, states were required to cover pregnant women and infants (defined as children under 1 year of age) with family incomes at or below 75 percent of the federal poverty level. Two subsequent federal laws further expanded mandated eligibility for children. By July 1991, states were required to cover (1) infants and children up to 6 years old with family income at or below 133 percent of the federal poverty level and (2) children 6 years old and older born after September 30, 1983, with family income at or below 100 percent of the federal poverty level.⁴ Since 1989, states have also had the option of covering infants with family income between 133 percent and 185 percent of the poverty level. States may expand Medicaid eligibility for children by phasing in coverage of children up to 19 years old more quickly than required, by increasing eligibility income levels, or both. The demographic analysis in this report, however, focuses on the group of children for whom coverage is mandated.

³G. Pappas and others, "Potentially Avoidable Hospitalizations: Inequities in Rates Between U.S. Socioeconomic Groups," *American Journal of Public Health*, Vol. 87, No. 5 (1997), pp. 811-22; Andrew Bindman and others, "Preventable Hospitalizations and Access to Health Care," *Journal of the American Medical Association*, Vol. 274, No. 4 (1995), pp. 305-11; and Carmen Casanova and Barbara Starfield, "Hospitalizations of Children and Access to Primary Care: A Cross-National Comparison," *International Journal of Health Services*, Vol. 25, No. 2 (1995), pp. 283-94.

⁴States have the option of dropping the resource (asset) eligibility requirement for these expansion populations. Forty states have discontinued using asset tests for some or all children.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), also known as the Welfare Reform Act, substantially altered AFDC and Supplemental Security Income (SSI) but made relatively few changes to the Medicaid program itself. The law replaced AFDC with a block grant that allowed states to set different income and resource (asset) eligibility standards for the new program—Temporary Assistance for Needy Families (TANF)—than for Medicaid. To ensure continued health coverage for low-income families, the law generally set Medicaid’s eligibility standards at AFDC levels in effect July 16, 1996, thereby ensuring that families who were eligible for Medicaid before welfare reform continued to qualify, regardless of their eligibility for states’ cash assistance programs.⁵ The law tightened the criteria for children to qualify for disability assistance through SSI, thus tightening eligibility for Medicaid.⁶ In addition, the law restricted aliens’ access to benefit programs, including SSI, and Medicaid benefits that were conditional on receipt of SSI. State and local governments were given some flexibility in designing policies that governed aliens’ eligibility for TANF, Medicaid, and social services. In a recently released report, we studied the Welfare Reform Act and its impact on Medicaid and found that in the states we visited, most chose to continue to provide Medicaid coverage to previously covered groups.⁷

The Balanced Budget Act of 1997 (P.L. 105-33) restored SSI eligibility and the derivative Medicaid benefits to all aliens receiving SSI at the time welfare reform was enacted and to all aliens legally residing in the United States on the date of enactment who become disabled in the future. At the same time, states continued to have flexibility in implementing certain benefits policies for aliens. Current law allows states the option of providing Medicaid coverage to aliens who were legal permanent residents in the country before August 23, 1996. States also have the option of covering legal residents who arrived after August 22, 1996, once they have resided in the United States for 5 years. Illegal aliens are eligible only for emergency services under Medicaid. (See table 1.)

⁵The law allows states to roll back their income eligibility levels to those in effect May 1, 1988. Approval from the Health Care Financing Administration (HCFA) is required to make such a change.

⁶These children might still qualify for Medicaid under alternative eligibility categories, and states are required to do redeterminations.

⁷Medicaid: Early Implications of Welfare Reform for Beneficiaries and States (GAO/HEHS-98-62, Feb. 24, 1998).

Table 1: Summary of Medicaid Eligibility for Aliens

Population	Policy
Qualified aliens arriving before August 23, 1996	
Legal permanent residents	State option
Asylees, refugees	Eligible for first 7 years of residency; state option afterward
Qualified aliens arriving after August 22, 1996	
Legal permanent residents	Barred for first 5 years of residency; state option afterward
Asylees, refugees	Eligible for first 7 years of residency; state option afterward
Unqualified aliens	
Illegal aliens	Emergency services only
PRUCOL aliens ^a	Emergency services only

^aPRUCOL (persons residing under color of law) is an umbrella term used for aliens who are legally residing in the United States but who do not fit in other alien categories.

The Balanced Budget Act also made two changes that directly affect children's coverage in the Medicaid program. It gives states the option of providing 12 months of continuous eligibility to children without a redetermination of eligibility, thereby avoiding the problem of children frequently moving on and off Medicaid as their parents' circumstances change. The act also allows states to extend Medicaid coverage to children on the basis of "presumptive eligibility" until a formal determination is made. Under this provision, certain qualified providers can make an initial determination of eligibility, based on income, that an individual is eligible. The individual is then required to apply formally for the program by the last day of the month following the month in which the determination of presumptive eligibility was made.

Finally, the Balanced Budget Act created the Children's Health Insurance Program (CHIP), a grant program for uninsured children, through which \$20.3 billion in new federal funds will be made available to states over the next 5 years. CHIP has a number of implications for Medicaid. If a state chooses to offer coverage through a separate program, the state must coordinate activities with the Medicaid program to ensure that Medicaid-eligible children are enrolled in Medicaid.⁸ The Congressional Budget Office estimated that the "outreach effect" of CHIP will result in an additional \$2.4 billion in Medicaid spending over the same 5 years due to increased enrollment of 460,000 Medicaid-eligible children each year. States may also use the grant funds to expand coverage under their state

⁸States will not receive any federal payments for CHIP if they adopt income or resource standards or methodologies for determining a child's eligibility for Medicaid that are more restrictive than those in effect on June 1, 1997.

Medicaid programs to reach additional low-income children, increasing the number of children potentially eligible for Medicaid.

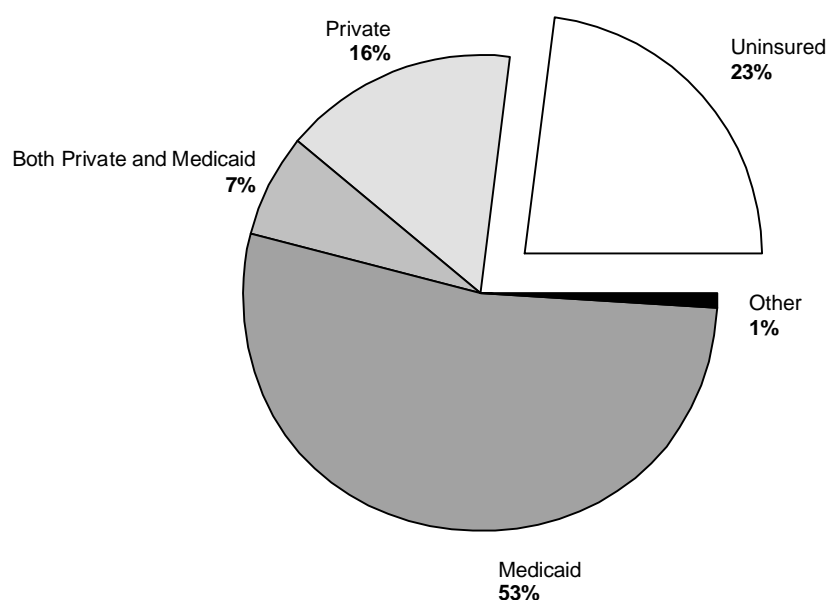
Medicaid-Eligible Children Who Are Uninsured Have Characteristics That Can Be Used to Target Outreach Efforts

Uninsured Medicaid-eligible children differ somewhat from those currently enrolled in Medicaid, and these differences can be used by states to focus their outreach and enrollment efforts.⁹ Overall, about 23 percent—or 3.4 million—of the 15 million children who were eligible for Medicaid were uninsured in 1996. Slightly over half of the Medicaid-eligible children are insured solely by Medicaid, while about 7 percent have both Medicaid and private coverage. The remainder have coverage through other public programs, such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or the Indian Health Service. (See fig. 1.) Medicaid-eligible children who are uninsured have characteristics closer to Medicaid-eligible children who are privately insured than to those with Medicaid.¹⁰ They are disproportionately children of the working poor, Hispanic, and U.S.-born children of foreign-born parents or foreign-born, and they are more likely to live in the West and the South.

⁹We define Medicaid-eligible children as those eligible for Medicaid by federally mandated age and income criteria: children under 6 years old with family income at or below 133 percent of the federal poverty level and children 6 through 12 years old with family income at or below federal poverty level.

¹⁰For a comparison of Medicaid-eligible children to all uninsured children, see S. Avruch and others, "The Demographic Characteristics of Medicaid-Eligible Uninsured Children," American Journal of Public Health, Vol. 88, No. 3 (1998), pp. 445-7.

Figure 1: Percentage of Medicaid-Eligible Children With Different Types of Health Insurance or Uninsured, 1996



Note: Uninsured children are children who are reported to have no insurance coverage at all for the entire year. Children reported as having health insurance coverage may have been uninsured for part of the year. Children with more than one source of coverage reported may have had duplicate coverage at the same time or may have had different types of coverage at different times of the year. For this figure, more than one source of coverage is shown only for children who have both private insurance and Medicaid coverage. Children with Medicare are included with the Medicaid group. Children with other coverage include those with insurance obtained through other public programs.

Uninsured Medicaid-Eligible Children Have Similarities With Privately Insured Children

Medicaid-eligible children are more likely to be uninsured if their parents work, if their parents are self-employed or employed by a small firm, or if they have a two-parent family. Children whose parents worked at all during the year—whether full-time, part-time, or for part of the year—are about twice as likely to be uninsured as those whose parents were unemployed. However, these children are more likely to be covered by employment-based insurance. The explanation for this apparent paradox is that children with employed parents are less likely to be covered by Medicaid, and employment-based coverage does not fully compensate for low rates of Medicaid participation. (See table 2.)

Table 2: Insurance Status of Medicaid-Eligible Children in 1996, by Parents' Work Status

Parents' work status	Insurance status		
	Percentage uninsured	Percentage enrolled in Medicaid ^a	Percentage with employment-based insurance ^a
Full-time for entire year	32.0	38.5	30.6
Less than full-time	21.2	62.1	22.7
Not working	13.0	81.1	8.2

Note: Table is based on 96 percent of Medicaid-eligible children whose records matched with those of their parents. (See app. I.)

^aIncludes children who have both Medicaid and employment-based health insurance coverage in the same year.

Small firms are less likely than larger firms to offer health insurance; therefore, it is not surprising that children whose parents are self-employed or employed by small firms are less likely to be insured. This could suggest selective targeting of smaller firms in Medicaid outreach efforts, especially if it is known that they do not offer insurance.

Half of all uninsured Medicaid-eligible children are in two-parent families, compared with only about 28 percent of those insured by Medicaid. The uninsured rate for Medicaid-eligible children is also higher in two-parent families than in single-parent families—30 percent compared with 18 percent. This again underscores that successful outreach efforts need to reach beyond the single unemployed mothers generally associated with both cash assistance programs and Medicaid.

Hispanics, U.S.-Born Children of Foreign-Born Parents, and Immigrant Children Are More Likely to Be Uninsured

Among racial and ethnic groups, the proportion of uninsured Medicaid-eligible children, as well as the proportion enrolled in Medicaid, varies by racial and ethnic group. Among uninsured Medicaid-eligible children, Hispanics have the highest uninsured rate, while blacks are most likely to be enrolled in Medicaid. (See table 3 and table II.1 in app. II.)

Table 3: Percentage of Medicaid-Eligible Children Uninsured and Percentage Enrolled in Medicaid in 1996, by Race and Ethnicity

	Percentage uninsured	Percentage enrolled in Medicaid
White	21.1	54.1
Black	18.9	69.4 ^a
Hispanic	29.2 ^b	58.8
Other, non-Hispanic	25.6	54.9
Total	23.0	59.7

^aStatistically different from percentage for whites and Hispanics.

^bStatistically different from percentage for whites and blacks.

In 1996, almost 9 out of every 10 uninsured Medicaid-eligible children were U.S.-born, but many—over one-third—lived in immigrant families. In addition to the 11 percent who were immigrants, another one-quarter had at least one foreign-born parent.¹¹ (See fig. 2.) The large number of children in immigrant families and the high proportion that are uninsured suggest that immigrant communities may be promising targets for outreach. (See table 4.) Over 70 percent of children in immigrant families are Hispanic, suggesting that outreach efforts be targeted to the Hispanic community as well as use Spanish-language outreach materials and applications.

¹¹We matched children to one parent—the one with the highest workforce participation—which might lead to a slight underestimate of children who had at least one foreign-born parent. However, in two-parent families, spouses generally had similar birth and immigration status. (See app. I.)

Figure 2: Medicaid-Eligible Uninsured Children in 1996, by Birth Status of Child and Parent

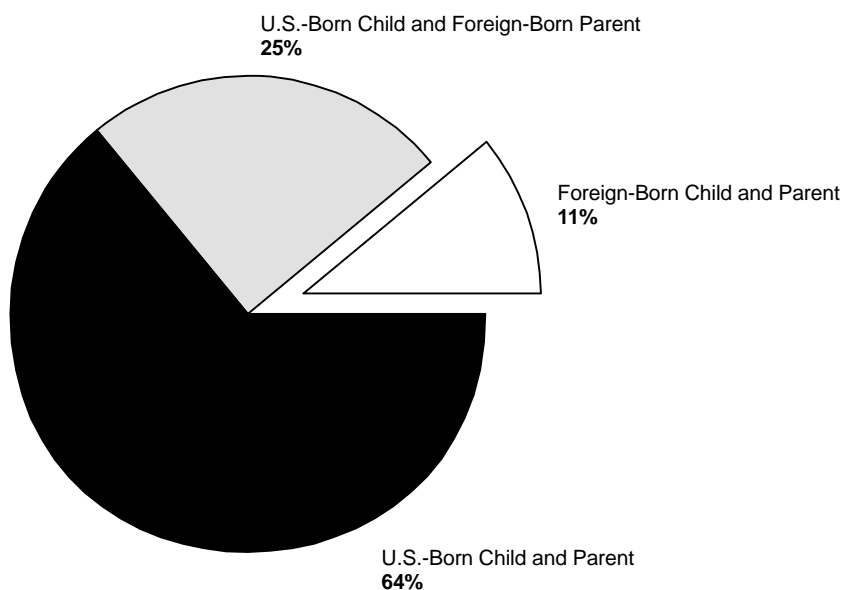


Table 4: Percentage of Medicaid-Eligible Children Insured and Uninsured in 1996, by Birth Status of Child and Parent

Characteristic	Percentage insured	Percentage uninsured	Total number
U.S.-born child with U.S.-born parent	81.7	18.3	11,140,000
U.S.-born child with foreign-born parent	70.1	29.9	2,648,000
Foreign-born child with foreign-born parent	44.5	55.5	631,000

Note: Table is based on 96 percent of Medicaid-eligible children whose records matched with those of their parents. Children were matched to the parent with the highest workforce participation. Less than 1 percent of children were foreign-born children with U.S.-born parents; these children were excluded from the table.

Many Uninsured Medicaid-Eligible Children Are School-Age or Have School-Age Siblings

Medicaid eligibility criteria allow younger children with higher family income to enroll. Children under 6 years old in families with income at or below 133 percent of the federal poverty level are eligible for the program, according to federal mandate, as compared with older children whose families' income must be at or below 100 percent of the federal poverty level. As a consequence, 54 percent of children who are Medicaid-eligible but uninsured are less than 6 years old. Nevertheless, outreach through schools could reach some of these younger children, since 42 percent have

a school-age sibling aged 6 to 17. This means that it could be possible to reach about 69 percent—or 2.4 million—of uninsured Medicaid-eligible children through schools.

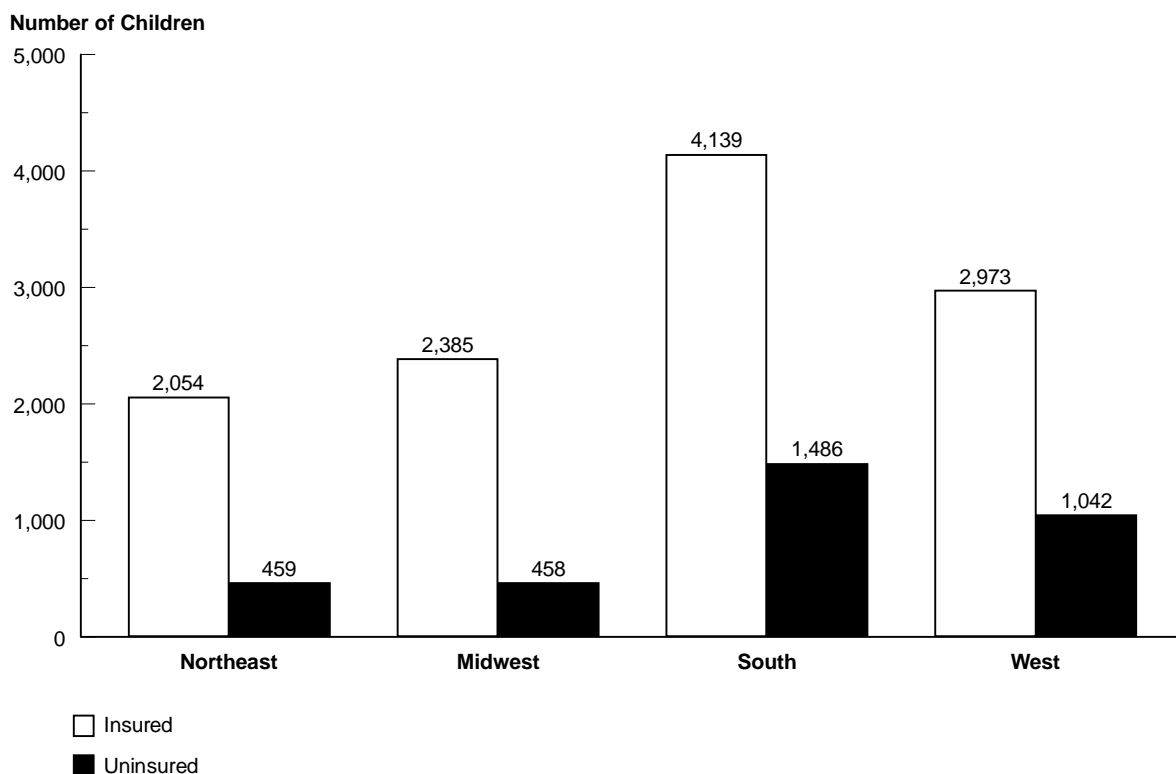
**Families of
Medicaid-Eligible
Uninsured Children Are
Less Likely to Enroll for
Food Stamps Than Other
Low-Income Families**

Other government programs could be used to reach families of uninsured Medicaid-eligible children, if they were using such programs. Use of government-subsidized services by these families might also indicate their willingness to access certain kinds of government-sponsored programs. While the CPS does not have information on use of public programs such as Head Start or the Department of Agriculture's Special Supplemental Food Program for Women, Infants, and Children (WIC), it does have information on family use of the Food Stamp program.

Compared with similar families with employment-based insurance or Medicaid coverage for their children, children who were Medicaid-eligible but uninsured were less likely to have been in families that received food stamps. Some experts have argued that immigrant families have been less willing to apply for subsidized benefits because of their fear of the government or language and cultural barriers. However, we did not find any significant difference in use of food stamps among uninsured Medicaid-eligible children with U.S.-born parents, foreign-born naturalized citizen parents, and foreign-born noncitizen parents.

**The West and the South
Face Different and Larger
Outreach Challenges**

The demographic makeup of the uninsured child population varies geographically and by community, meaning that national analyses can only suggest potential outreach targets and must be validated in the light of local knowledge. Nonetheless, it is clear that the West and the South as a whole face particular challenges. A larger proportion of Medicaid-eligible children in these regions are uninsured—overall, the West and the South account for 73 percent of all uninsured Medicaid-eligible children nationwide. (See fig. 3.)

Figure 3: Number of Medicaid-Eligible Children With and Without Health Insurance in 1996, by Region

Note: Numbers in thousands.

Several reasons may explain the differences in proportions of uninsured Medicaid-eligible children in different regions. Some areas have higher proportions of workers with employment-based insurance because of the size of local firms, type of business, or degree of unionization. As a result, higher proportions of workers' dependents are insured. Regions also differ in the number and percentage of immigrant families and various ethnic groups. All of these factors can affect insurance status and how states conduct outreach to the uninsured.

Regions differ in the number of uninsured Medicaid-eligible children who are Hispanic or of Hispanic descent and in the number who are members of immigrant families. Both Hispanic and immigrant families are most

prevalent in the West, particularly in California, where over 60 percent of uninsured Medicaid-eligible children are Hispanic and over 70 percent live in immigrant families. (See tables II.2 and II.3 in app. II.)

Although some differences among states are due to states' demographic characteristics, differences may also be due to states' varying efforts to extend health insurance to those who have been unable to receive coverage and to inform these individuals of their eligibility. Having a larger, more visible program is a mechanism that may help. Some states have expanded Medicaid eligibility further for children than other states and may have attracted more of their poorer Medicaid-eligible children to enroll.¹²

Limited Enrollment Due to Several Factors

When asked why families do not enroll their Medicaid-eligible children in the program, state officials, beneficiary advocates, health care providers, and other experts report a variety of contributing factors. Some families do not know about the program or do not perceive a need for its benefits. Some families, especially those who have never enrolled in public benefit programs, may not even be aware that they are eligible. In addition, some parents may associate Medicaid with welfare and dependency, and therefore have an aversion to enrolling their children in the program. Cultural and language differences may limit awareness or understanding, and immigration status may also affect a family's willingness to apply. Finally, the eligibility process can be difficult for working families because of the limits on where and when enrollment can take place, the lengthy application, and the documentation required. These barriers to the enrollment process can be reduced, but in reducing the length of the application and the amount of documentation a balance must be struck between maximizing enrollment and minimizing program abuse.

Families May Lack Knowledge of Medicaid and Its Eligibility Criteria

Most state officials, advocates, providers, and other experts whom we interviewed agreed that many families are unaware of Medicaid. Even families who know about the program may not realize that they could be eligible. With the long-standing link between Medicaid and AFDC, many families—both those who have never received welfare and those who have—assume that if they are not receiving cash assistance, they are not eligible for Medicaid. Two types of families tend to be unaware of their

¹²States like Washington, Tennessee, and Minnesota developed subsidized health insurance for low-income families, partially or entirely funded through Medicaid. They may also have reduced the percentage of uninsured Medicaid-eligible children through attracting low-income uninsured families to their program.

eligibility: working families who assume that Medicaid eligibility is tied to welfare eligibility and families who were previously on welfare and believe that, because of welfare reform, they are no longer eligible for Medicaid. These families are unlikely to understand that children with higher levels of family income may be eligible for Medicaid. Complex eligibility rules—which can result in younger children being eligible while their elder siblings are not—can simply add to families’ confusion.

Families May Not Perceive a Need for Medicaid Due to Good Health and Alternative Sources of Care

Several state officials, providers, and one expert told us that some families do not become concerned about health care access until their children become sick and, therefore, do not enroll them in Medicaid—especially if the children are relatively healthy. In addition, if families have successfully sought and received care for their children from clinics or emergency rooms in the past without enrolling in a health care program such as Medicaid, they are likely to continue to seek care from these providers.

Cultural Differences, Language Barriers, and Immigration Policies May Keep Some Families From Enrolling in Medicaid

State officials, advocates, and other experts told us that some families are hesitant to enroll in Medicaid because of cultural differences, language barriers, and their understanding of U.S. immigration policies. Experts and a state official said that cultural differences may keep immigrant families from enrolling in Medicaid. Language was often mentioned as a barrier. Individuals who cannot read the Medicaid application and informational materials and cannot easily converse with eligibility workers by telephone or in person are at a distinct disadvantage. One expert told us that the degree of acculturation has a major impact on whether an immigrant will use public assistance of any kind. While time spent in the country is the main predictor of acculturation, some individuals may not participate in mainstream society and use its institutions even after living in the country for many years.

According to some state officials, advocates, and experts, immigrant families may also hesitate to enroll in Medicaid because they are concerned that it will negatively affect their immigration status. Immigrants who are legal residents may be afraid that if they receive benefits that they will be labeled a “public charge” and will have difficulties with the Immigration and Naturalization Service (INS) when applying for naturalization, visa renewal, or reentry into the United

States.¹³ Although advocates question whether aliens receiving benefits may be considered public charges, in some instances actions have been taken against such individuals seeking visa renewals. Several advocates also told us about cases where individuals were prevented from reentering the United States unless they agreed to reimburse Medicaid for services paid for by the program on their behalf—particularly in border states such as California.¹⁴ Publicity about such cases in the immigrant community can deter immigrants from applying for Medicaid benefits for themselves or their children—even in cases where the children were born in the United States and are American citizens.

In families where one or more adults are in the country illegally, the reluctance to seek Medicaid benefits for a child may be even greater. When applying for Medicaid for children, families in some states are asked about the immigration status of other members of the household. Again, advocates told us this is a deterrent to enrollment for such families and reported that many immigrant families, both legal and illegal, seek medical assistance through county clinics and public hospitals because these institutions are viewed as more sympathetic and less likely to ask questions about immigration status.

Perceived Negative Image Attached to Medicaid May Deter Enrollment

State officials and other experts told us that because of its long-standing ties with welfare and other benefit programs, many families associate Medicaid with a family that cannot provide for itself. Experts report that many working poor and near poor do not want to be labeled as welfare recipients, even if the law entitles their children to benefits. They often take the view that they never have received welfare and do not want to start.

Enrollment Process Can Be a Barrier

State officials, beneficiary advocates, providers, and other experts agree that Medicaid enrollment processes and requirements have often been

¹³Aliens may be excluded from entering the United States if it is determined that they are likely to become public charges. If already in the United States, they may be deported if they have become public charges. Neither the law nor the regulations specify whether receipt of benefits such as Medicaid would cause someone to be deemed a public charge.

¹⁴In a December 17, 1997, letter to state Medicaid directors, HCFA stated that when an alien has legitimately received Medicaid benefits, the beneficiary is not indebted to the state. The letter also said that states do not have the authority to collect repayments of benefits from current or former beneficiaries except in cases where those benefits were fraudulently received or an overpayment had occurred. Further, the letter said that state Medicaid agencies are not authorized to provide information about the receipt of benefits or the dollar amount of these benefits to INS, the State Department, or immigration judges. In a December 17, 1997, memorandum to its offices, INS said that it does not have the authority to require or request that aliens repay public benefits, and lawful permanent residents who have been outside the United States 180 days or less should not be questioned on issues related to the likelihood that they would be a public charge.

barriers. However, to ensure that all recipients of Medicaid benefits meet income and other requirements, states have found it necessary to develop application processes that

- use lengthy application forms and
- require extensive documentation.

State officials, beneficiary advocates, and other experts told us that lengthy enrollment forms and the associated documentation requirements create a barrier for families. Long forms are often used when a family is applying for a combination of programs, including Medicaid. Numerous questions relating to income, assets, citizenship, and family composition are used to determine eligibility and to ensure that only those who are entitled to benefits are enrolled in Medicaid. In addition to length, enrollment forms often require extensive documentation. Families are asked to provide paystubs, bank account statements, birth certificates, and other documents that verify the information they provide on the forms. Gathering such documents can be burdensome. For example, obtaining a birth certificate can involve going to a different office and then returning to the eligibility office. Obtaining certain documents can also require a family to pay a fee.

A valid and reliable eligibility determination process is important to state officials to ensure program integrity. In addition, states can be assessed a financial penalty by the federal government if their error rates are too high. In an effort to balance these needs, most states have developed shorter forms for children who are applying exclusively for Medicaid, primarily by dropping the asset requirements. Some advocates, however, are still concerned with the length and complexity of application forms and the number of questions they contain. One advocate suggested that if applicants cannot understand the form, they are not going to fill it out. Another advocate pointed out that some questions may be well-intended, but they nonetheless lengthen the application. For example, as a way of identifying if the family may be eligible for other benefit programs, some states' applications ask questions related to disability. In addition, advocates pointed out that the documentation requirements are so stringent in some states that many applicants are denied enrollment because they cannot produce the documentation required. In an earlier report, we found that such requirements were shown to account for nearly half of all denials.¹⁵

¹⁵Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People (GAO/HEHS-94-176, July 11, 1994).

In addition to limits that were developed as part of a legitimate effort to maximize the accuracy of eligibility determinations and monitor the eligibility process, other barriers exist. These include

- location of enrollment sites and enrollment hours;
- fluctuations in eligibility status, including the impact of welfare reform; and
- families' lack of transportation and communication problems.

Many of the state officials and other experts with whom we spoke said that the enrollment process used for welfare was difficult for working families because enrollment locations are limited and open only during typical work hours. This makes it difficult for working parents in families whose children may be eligible for Medicaid to apply. Such parents may not have the flexibility in their job to take time off to enroll through face-to-face interviews, according to one state official and one expert. States are required to provide for the receipt and initial processing of applications for pregnant women, infants, and children at sites not used for AFDC applications—such as federally qualified health centers and hospitals that serve a larger share of uninsured and publicly insured persons—but these efforts may have been limited.

Experts also noted that the eligibility system does not accommodate the fluctuating eligibility status of many families. Low-income working families may have changes in their income if they work seasonally or change or lose jobs. A family eligible one month may not be eligible the next month because of an increase in family income, but children in that family may still be covered under other categories of eligibility. According to experts, some states' eligibility processes do not automatically make redeterminations to see if children who lose their eligibility might be eligible in another category. If the family does not reapply, the child loses coverage.

Advocates have also been concerned that welfare reform may make enrollment less likely. Families may be confused about their Medicaid eligibility because, prior to welfare reform, Medicaid and cash assistance had, historically, been so closely linked. For example, if TANF enrollment workers focus on job search strategies and not on benefits, families who come in may not be enrolled for Medicaid. In addition, some families may believe Medicaid is time limited as is TANF.

According to experts, advocates, and one provider, limits on the ability to communicate and availability of transportation can be a barrier for applicants. In addition to difficulties for non-English-speaking families, illiteracy may also limit a parent's ability to enroll without substantial assistance. Experts also pointed out that lack of transportation to enrollment sites can be a barrier, primarily in rural areas, but also in some urban settings. A family may not have a car or have limited time and money to make a long trip to the welfare office.

Some States Use Innovative Strategies to Target Outreach and Encourage Enrollment

To enroll eligible children in Medicaid, some states are using innovative strategies that are intended to increase knowledge and awareness of the program and its benefits, minimize the perceived social stigma, and simplify and streamline the eligibility process. Education and outreach programs are often targeted to families who have children potentially eligible for Medicaid. Visible support from state leadership and partnerships with community groups are viewed by state officials and advocates as essential to obtaining the necessary resources to implement outreach programs. Some states have even renamed the Medicaid program as a way to change its image. To improve the enrollment process, some states have adopted strategies to assist immigrant families or have simplified and streamlined the eligibility process by shortening forms and accepting applications at many new sites, as well as mail-in applications. However, this kind of simplification and streamlining has required state officials to make difficult trade-offs between the need for program integrity and higher Medicaid enrollment.

Multifaceted Outreach Programs Intended to Educate Targeted Families

The states that we contacted have developed multifaceted outreach programs to educate families on the availability of the Medicaid program and the importance of enrolling their children. They generally agreed that a successful education and outreach program should

- target outreach to low-income working families with children, using nontraditional methods and locations, and
- work in collaboration with community groups, schools, providers, and advocates.

These themes are broadly consistent with several findings from our demographic analysis: low-income working families with children have a high uninsured rate, and most uninsured Medicaid-eligible children are in

school or have a sibling in school, which makes the schools an available avenue for reaching children and families.

The states that we studied have employed a variety of methods to publicize Medicaid. For example, Massachusetts has placed outreach workers in health centers, hospitals, and other traditional locations; distributed literature in schools; sent material to the YMCA and other community groups; and worked with a supermarket chain to place in grocery bags notices of the program. The governor has held several press conferences around the state to publicize the program, and the state is working with workers in WIC clinics, who are already trained to do income-based eligibility assessments. The state has also used its enrollment data to target communities that have low levels of Medicaid enrollment and worked with local officials to address the problem. The state's private contractor for managed care enrollment has also assisted with outreach through its presentations in the community. One advocacy group worked with the state to develop a campaign to target high-school athletes, who are required to have health insurance. This campaign involved sending posters and fold-out fliers—developed and produced with the donated time of professionals—to athletic directors in high schools throughout the state and establishing a pool of student athletes to go out and talk to their peers. In another initiative, the state medical society is training its members' staffs to assist in educating families about program eligibility and benefits. Finally, Massachusetts is making \$600,000 available to help community groups conduct outreach and educate families of uninsured Medicaid-eligible children, with the money distributed as grants in amounts between \$10,000 and \$20,000.

In Arkansas, as part of a large media campaign that included television and radio announcements, the state placed color inserts in Sunday newspapers during September 1997. These inserts provided information on program eligibility and benefits, a toll-free number to obtain additional information, as well as a photograph of children with the governor endorsing the program. The state's children's hospital paid for the insert. Applications are available at schools, pharmacies, and churches, and brochures have also been placed in fast food bags. The state has also worked with its children's hospital to place enrollment forms at affiliated clinics, which are located throughout the state.

Georgia has made a major commitment to outreach by employing over 140 eligibility workers with the specific job of getting eligible children and families enrolled in Medicaid. These outreach workers are situated in

numerous locations, including health departments, clinics, and hospitals. These workers also temporarily set up at nontraditional sites, such as schools, community agencies, and shopping malls. The outreach workers are often available during evening and weekend hours as a convenience to working families. Workers also make presentations regularly to community groups, medical providers, and employers. A flier was developed that is targeted to employers to inform them about benefit programs for which their employees may be eligible. Georgia is also trying to enroll former welfare recipients by emphasizing Medicaid enrollment as an important part of a successful transition to work. The state's outreach program has also established partnerships with numerous community groups—including local coordinating councils, local teen pregnancy task forces, and school boards—and has used these local partnerships to develop outreach tailored to needs and characteristics of the communities. The state's private contractor for enrollment in managed care has also assisted with the outreach program through its contacts with the community.

In view of its recent welfare reform initiatives, Wisconsin is making a concerted effort to ensure that Medicaid-eligible individuals enroll in Medicaid regardless of their eligibility for the state welfare program. As part of this outreach effort, the state has begun to target county eligibility workers, individual providers, and Medicaid-eligible individuals to communicate that people may still qualify for medical assistance apart from their eligibility for welfare. Additional resources have been made available for outreach, outstationing, and training materials for staff. To plan its outreach efforts, the state is working with outside groups, including the Primary Health Care Association, the state medical society, Milwaukee County, Children's Hospital, and Marshfield Clinic.

Few States Tailor Programs to Immigrant and Ethnic Communities

We found less targeting of immigrant communities than might have been expected from the demographic analysis, although this was in some measure due to the characteristics of the states that we selected for our study. However, advocates report concern within the immigrant communities that receiving benefits will compromise their immigration status. One expert told us that some states have attempted to assist eligible immigrant families in enrolling their children by providing enrollment information and applications in alternative languages, particularly Spanish, and by hiring bilingual enrollment workers. In general, their outreach approach is similar to those tailored to other communities but with an emphasis on particular immigrant and ethnic

cultures and languages. Massachusetts is working with local community groups that provide information and educate immigrants on the availability of Medicaid. Georgia's outreach workers give presentations to employee groups within firms that have a large proportion of Hispanic immigrants among their workers.

In their outreach efforts, states face challenges with the immigrant community because they have to take into account the recent changes of the Welfare Reform Act and the Balanced Budget Act, which make benefits a state option for qualified immigrants who arrived before August 23, 1996, and bar immigrants for 5 years if they arrived after August 22, 1996. However, these limitations do not affect the eligibility of native-born children in immigrant families.

Name Change and Outreach Initiatives Intended to Project More Positive Program Image

States have tried to change the perception that Medicaid is tied to welfare and dependency in a variety of ways. The most direct method for changing the program's image is changing the program's name. In addition, states have advertised the program as one that is intended for working families, while some have included policies to avoid displacing private health insurance. They have also adopted alternative enrollment methods so that individuals do not have to go to the local welfare office to enroll.

Changing the Medicaid program's name is not new, but it has become more widespread.¹⁶ Massachusetts recently renamed its program MassHealth with the intent that it would be more appealing to beneficiaries. MassHealth fliers describe several option plans available (six in total), referring to them by names such as "MassHealth Standard" and "MassHealth Basic"—names similar to commercial health plans. Arkansas named its Medicaid expansion program for children ARKids 1st. The logo for the program uses bright colors with the "1" in 1st represented by a crayon. Georgia has not changed the name of Medicaid, but its outreach project is called "Right From the Start" to project a positive message.¹⁷

Advertisements and fliers for these programs emphasize that they are for a broad population, not just those on welfare. MassHealth fliers state,

¹⁶Some states changed their Medicaid name for pregnant women and infants when they began outreach to these populations in the late 1980s.

¹⁷States also often provide identification cards that look like cards in commercial plans. This is also prevalent in managed care programs where the beneficiary gets the same managed care plan card as non-Medicaid members.

“There is no reason why a child or a teen in Massachusetts should go without health care.” Massachusetts has fliers that outline income levels for eligibility that show families with almost \$2,400 a month in income and pregnant women with income up to \$3,300 a month as eligible. Georgia has a flier entitled, “Have you heard about benefits for working families?,” and the first program mentioned is Medicaid for children. Another flier targeted to families leaving welfare to work asks the question, “Did you know you could work full time and still receive some benefits?” (See fig. 4.)

Figure 4: Outreach Materials From Arkansas, Georgia, and Massachusetts

Arkansas

Are Your Children Missing the Health Insurance Coverage They Deserve?



Enroll Today. 1-888-474-8275

ARKids 1st
Insuring Our Children
and Our Future.

Massachusetts

There is no reason why a child or a teen in Massachusetts should go without health care.



Every uninsured child and teen in Massachusetts can get health care coverage at little or no cost. Children aged 18 and younger can enroll in a program with either full coverage or primary and preventive care. The kind of coverage you get depends on your family income. You can get services no matter what your immigration status is. The information you give us when you apply is confidential and is not shared with other agencies.



MassHealth

The Children's Medical Security Plan

MassHealth is a health insurance program with a full range of benefits. It pays for doctors' office visits, prescription drugs, dental services, counseling, hospital services, and other health-care services. In many cases parents can get MassHealth as well as children.

Children in families not eligible for MassHealth can get more limited coverage for primary and preventive care through the Children's Medical Security Plan. CMSP does not pay for hospital services. Some families may have to pay a small monthly fee, depending on their income.



Call for more information:

MassHealth
1-800-841-2900

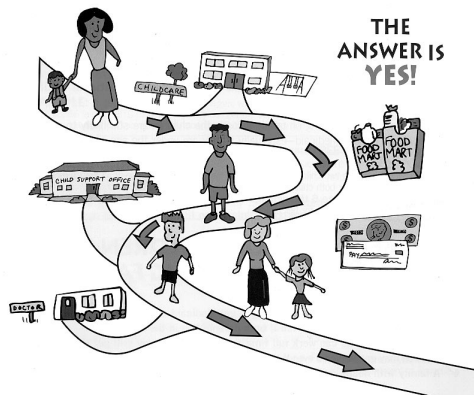
CMSP
1-800-909-CMSP (2677)



Georgia

LEAVING WELFARE FOR WORK ISN'T AS SCARY AS IT SEEMS

DID YOU KNOW YOU COULD WORK FULL TIME AND STILL RECEIVE SOME BENEFITS?



Cover

WHAT ARE THE BENEFITS FOR FAMILIES WHO LEAVE WELFARE FOR WORK?

- Medicaid (doctor visits, medicine, hospital care and checkups)
- Child care assistance
- More take home pay
- Food Stamps
- Free help with filing tax return

HEALTH COVERAGE



Families who get off of welfare because of work may still get family health coverage for parents and children for up to one year! It's called **Transitional Medicaid Assistance (TMA)**.

After one year, depending on family income, the children are still likely to get health coverage through Medicaid—especially if they are under the age of six.

EXAMPLES:

In 1996, a mother with two children under age 6 can have gross income of \$1,529 a month and get Medicaid coverage for both children.

If the two children are age 6 through age 18, she can have gross income of \$1,172 a month and still get Medicaid coverage for her children.

MEDICAID FOR CHILDREN IN LOW INCOME WORKING FAMILIES

- ✓ Children through age 18 may get Medicaid.
- ✓ Children do not have to be on welfare to get Medicaid.
- ✓ Children may get Medicaid even if both parents live in the home.
- ✓ One or both parents can work full time, and the children may still get Medicaid.
- ✓ Children may get Medicaid even if their family has a car, a house and a savings account.
- ✓ A family with health insurance may still get Medicaid for their children.

Inside Page

To minimize the possibility of displacing private insurance, known as “crowd out,” some states have policies to address the issue. The Medicaid program cannot refuse enrollment to any eligible individual based on the fact that he or she has insurance, although Medicaid is the payer of last resort. However, some states that have expanded eligibility through waivers of normal program rules have been allowed to limit eligibility if a family already has insurance. For example, in Arkansas, which received a waiver for its expansion, a child is not eligible for ARKids 1st unless he or she has been uninsured for a period of 12 months or the child lost insurance coverage during that period through no fault of the family. In Massachusetts (which also has a waiver for expansion) and Georgia, officials are cognizant of the potential dangers of crowd out. Massachusetts, as part of MassHealth, will subsidize the cost of insurance available to the family.

States Change Enrollment Process in Various Ways to Attract Working Families

Some states have developed a number of strategies to make the enrollment process easier for working families. Several states, as part of their outreach effort, have outstationed eligibility workers in sites that families frequent as an alternative to enrolling at the welfare office. In addition, states have simplified and shortened their enrollment applications, allowed applications by mail, dropped asset requirements, and reduced documentation requirements. To help ensure continued coverage of children in families whose income fluctuates, states can provide continuous eligibility. Of the states we contacted, only Arkansas has adopted continuous eligibility for a year for children.

Some states have adopted enrollment methods that do not require individuals to visit a welfare office, in part to minimize Medicaid’s association with welfare and welfare families. If families are only seeking Medicaid enrollment for children, Massachusetts and Arkansas allow families to ask questions and request an application by telephone. These two states also accept applications by mail. Completing applications with outreach workers at various nontraditional sites is another way the process is made easier for working families and those without transportation.

Each of the states with whom we spoke had shortened and simplified their enrollment form. Massachusetts officials used focus groups to find out why families did not enroll their children and how barriers to enrollment could be removed. Suggestions from the focus groups—such as adding more space on the enrollment form—helped the state design a simplified

form that is easier to read. States have had the option of dropping the asset tests for certain populations. When Arkansas dropped its asset test for the ARKids 1st program, it also dropped the related questions about assets and property, shortening the enrollment form to four pages. Georgia also shortened its enrollment form and dropped the asset test.

States are concerned with maintaining program integrity and ensuring that benefits go only to qualified individuals. However, 40 states have abolished the asset test for some or all children, primarily because the likelihood that these families have substantial assets is low. Table 5 shows the number of states that have made these changes.

Table 5: Number of States That Have Made Changes to the Enrollment Process

Dropped asset test	40 ^a
Shortened eligibility form	30
Adopted mail-in enrollment	25

^aFour states have dropped their asset test for some but not all eligible children.

Source: Center on Budget and Policy Priorities.

Few efforts have been made to address the problem of fluctuating family eligibility status, causing children to be inappropriately disenrolled from Medicaid. As part of its ARKids 1st program, Arkansas is providing 12 months of continuous eligibility to children regardless of changes in family income, under waiver authority granted by HCFA. Until recently, states had to receive a waiver to pursue such a policy. The Balanced Budget Act, however, allows states to adopt 12 months of continuous eligibility.

To date, welfare reform has not significantly affected the application process for Medicaid. In a recent report, we found that nine states we contacted have chosen to make few structural changes in their Medicaid programs in the first full year of implementing welfare reform. For example, while the Welfare Reform Act delinked eligibility for cash assistance and Medicaid, the states that we contacted had generally decided not to separate Medicaid and cash assistance program administration. In three of the states that we spoke with for this study, welfare applicants received a combined form that permits families to apply for both cash assistance and Medicaid, but families applying only for Medicaid receive a shorter form with a subset of questions.

Conclusions

Despite the importance of and large investment in providing health care to children in low-income families, difficulties in enrolling them in Medicaid leave more than 3 million children vulnerable. The states that we reviewed recognized that uninsured Medicaid-eligible children are generally in working two-parent families and have targeted their outreach accordingly. Targeting working families raises the issue of crowd out—replacing employer-based insurance with Medicaid—but states that we contacted have not seen this as a major problem given the low income levels of these families. Only Arkansas has taken direct action to discourage employers from dropping health insurance coverage by enforcing a 12-month waiting period.

We found less outreach targeted to Hispanics and immigrants, and experts whom we interviewed said this was generally true, even in states with large immigrant or Hispanic populations. Immigrants, particularly families in which the parents are not naturalized U.S. citizens, are likely to be a more difficult group to reach, both because of the complexities of the law, which makes some but not all immigrant children eligible for Medicaid, and because of the immigrants' general wariness of government. Some immigrant families include children who—because they were born in this country—are citizens and fully eligible for Medicaid.

The states that we studied are, for the most part, using outreach and enrollment strategies available for some time—but not necessarily used for enrolling uninsured children. However, other strategies provided for by the Balanced Budget Act—such as continuous enrollment and presumptive eligibility—have not been widely implemented. CHIP also has considerable potential for identifying uninsured Medicaid-eligible children. The law provides that any child who applies for CHIP and is determined to be Medicaid-eligible should be enrolled in Medicaid. The more that states publicize CHIP, the greater the number of uninsured Medicaid-eligible children they are likely to identify and enroll in Medicaid—particularly if the states' screening and enrollment process effectively identifies Medicaid-eligible children and enrolls them in the Medicaid program.

Agency Comments

We sought comments on a draft of this report from HCFA; from state officials in Arkansas, Georgia, Massachusetts, and Wisconsin; and from experts on children's health insurance issues with the Southern Institute on Children and Families and the Center on Budget and Policy Priorities. A number of these officials provided technical or clarifying comments, which we incorporated as appropriate. In addition, HCFA noted that it had

sent a letter dated January 23, 1998, to state officials to encourage them to simplify enrollment and expand outreach to the Medicaid-eligible population.

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of HCFA, the directors of the state programs we spoke with; and interested congressional committees. Copies of the report will be made available to others upon request.

If you or your staff have any questions about the information in this report, please call me or Phyllis Thorburn, Assistant Director, at (202) 512-7114. Other contributors to this report were Richard Jensen, Sheila Avruch, and Sarah Lamb.

Sincerely yours,

A handwritten signature in black ink that reads "William J. Scanlon". The signature is written in a cursive, flowing style.

William J. Scanlon
Director, Health Financing and
Systems Issues

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Abbreviations

AFDC	Aid to Families With Dependent Children
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHIP	Children's Health Insurance Program
CPS	Current Population Survey
CTS	Community Tracking Study
HCFA	Health Care Financing Administration
INS	Immigration and Naturalization Service
PRUCOL	persons residing under color of law
SIPP	Survey of Income and Program Participation
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
WIC	Special Supplemental Food Program for Women, Infants, and Children

Scope and Methodology

To examine the demographic characteristics of Medicaid-eligible uninsured children, we analyzed the Current Population Survey (CPS), which is used by some researchers to measure health insurance coverage in the United States. This technical appendix discusses the survey, how we measured insurance coverage and estimated Medicaid-eligible children, and how we determined parents' work effort and immigration status. It also discusses some concerns about how well the CPS measures insurance coverage and compares our estimate of the number of Medicaid-eligible uninsured children with other analysts' estimates.

About the CPS

The CPS, a monthly survey conducted by the Bureau of the Census, is the source of official government statistics on employment and unemployment. Although the main purpose of the survey is to collect information on employment, an important secondary purpose is to collect information on the demographic status of the population, such as age, sex, race, marital status, educational attainment, and family structure. The March supplement of the CPS survey collects additional data on work experience, income, noncash benefits, and health insurance coverage of each household member at any time during the previous year.

The CPS sample is based on the civilian, noninstitutionalized population of the United States. About 48,000 households with approximately 94,000 persons 15 years old and older and approximately 28,000 children aged 0 to 14 years old are interviewed monthly. The sample also includes about 450 armed forces members living in households that include civilians and are either on or off a military base. For the March supplement, an additional 2,500 Hispanic households are interviewed. The households sampled by the CPS are scientifically selected on the basis of area of residence to represent the United States as a whole, individual states, and other specified areas.

How We Defined Insurance, Medicaid Eligibility, and Family Status

Health Insurance Coverage Status

Children can have multiple sources of health insurance coverage in the same year. The CPS asks about all sources of health insurance coverage. It

is impossible to tell, for example, if a child is reported as having both Medicaid and employment-based insurance, whether the child had duplicate coverage, had Medicaid coverage first and then employment-based coverage, or vice versa. For this report, children who had employment-based insurance were reported as having such coverage even if they also had other sources of coverage. Likewise, children who had Medicaid coverage were reported as having such coverage even if they had other sources of coverage. As result, some children were reported as having both public and private coverage—usually Medicaid and employment-based insurance—for the same year. (See fig. 1.)

For this report, children who are uninsured are children for whom no source of coverage during the entire previous year is reported. CPS asks specific questions about whether any members of the household have coverage provided through an employer or union; purchased directly; or have Medicare, Medicaid, or other public coverage. However, it does not directly ask whether an individual is uninsured if no source of coverage is reported.

Medicaid-Eligible Children Who Are Uninsured

We defined Medicaid-eligible children in 1996 as children eligible by federal mandate based on age and poverty criteria—children from birth through 5 years old with family income at or below 133 percent of the federal poverty level and children 6 through 12 years old with family income at or below the poverty level.

We used income in the immediate family rather than the household income to calculate poverty levels. We did this because states have specific rules on what income can be deemed available to the child to determine Medicaid eligibility, and it may not include income provided to the household by people not related to the child. In addition, employment-based health insurance is usually only available to immediate dependents; therefore, the income and work effort within the nuclear family is more relevant to whether or not the child is insured.

Matching Children With Parents

We matched children's records with parents' records to analyze family characteristics. CPS considers a family to be two or more persons residing together and related by birth, marriage, or adoption. The Census Bureau develops family records for the householder (a person in whose name the housing unit is owned, leased, or rented or, if no such person, an adult in the household); other relatives of the householder with their own

subfamilies; and unrelated subfamilies. If the house is owned, leased, or rented jointly by a married couple, the householder may be either the husband or wife. We paired children's records to their parents' records or, lacking a parent, another adult relative (aged 18 through 64) in their immediate family whom we called a parent. After this pairing, we matched the adult family member's record to his or her spouse's record, if any, to get "parents" in our file. We were not able to match all children's records with records of parents or other relatives in their households. For Medicaid-eligible children, we matched 96 percent of the children's records. For Medicaid-eligible uninsured children, we matched 92 percent of the children's records. Some of our tables and figures are based on the entire file of children's records; others are based on the matched file and are so indicated.

Determining Parents' Work and Education Status

Matching parents with children to analyze the association of workforce participation and insurance for children helped us develop a more accurate picture of uninsured and Medicaid-insured children with working parents. We analyzed parent work status on the basis of information about the parent who worked the most. (See table I.1.) This allowed us to more accurately portray the work status of parents in two-parent families. Where two parents were working in the same status—such as full-time—we matched to the first parent in that work status.

Table I.1: Definition of Work Status of Parent or Parents

Work status	Reported as	Definition
Full-time, full year	Full-time, full year	Either parent worked full-time, full year.
Full-time, part year	Less than full-time, full year	Neither parent worked full-time, full year, but at least one worked full-time part of the year.
Part-time, full year	Less than full-time, full year	Neither parent worked full-time, but at least one parent worked part-time for the entire year.
Part-time, part year	Less than full-time, full year	Neither parent worked either full-time or full year, but at least one parent worked part-time for part of the year.
Not working	Not working	Neither parent worked at all during the entire year.

We used the parent with the greater workforce participation to determine children's birth and immigration status relative to their parents'. This could lead to a slight underestimate of children in immigrant families, since in some two-parent families, spouses do not have the same birth or citizenship status. However, spouses generally share similar birth and

citizenship status. We examined birth and citizenship status of one parent compared with the other in two-parent families and found that over 90 percent had the same birth and citizenship status as their spouse. Since only about half of Medicaid-eligible children live in two-parent families to begin with, matching to one parent would lead to over 95 percent of children being accurately categorized, based on a match with one parent.

Comparing CPS and Other Surveys

Some researchers who work with survey data to assess health insurance status of the U.S. population are concerned that the currently used surveys, including CPS, may not accurately reflect health insurance coverage in the United States.¹⁸ CPS and the Survey of Income and Program Participation (SIPP)—another survey that is often used to assess health insurance coverage—report lower Medicaid coverage than HCFA data on Medicaid enrollment. Comparing CPS and SIPP data for similar periods of time, some researchers have concluded that although the CPS asks about insurance coverage for the entire previous year, respondents are reporting coverage based on a shorter time frame—perhaps 4 to 6 months. Researchers at the Urban Institute have concluded that some of the uninsured actually have coverage, probably Medicaid coverage, and adjust their estimates of the uninsured accordingly.

Although health researchers are concerned that the CPS may not be ideal for analyzing health insurance coverage, neither is any other currently available survey. Therefore, many researchers continue to use it. GAO chose to use CPS data for its analysis of children's health insurance coverage for several reasons. The CPS can be used to look at trends over time, although care must be taken when making comparisons between years because of questionnaire and methodological changes. It has a large sample, which gives estimates from the data more statistical power. It was designed so that it can be used for some state-level estimates.

Information from new health insurance surveys is or is becoming available. The National Health Interview Survey periodically asks questions about health insurance coverage, and the Agency for Health Care Policy and Research has released preliminary 1996 estimates of health insurance coverage from the Medical Expenditure Panel Survey. The Center for Studying Health System Change has surveyed health insurance coverage in 1996 and 1997 in its Community Tracking Study (CTS) and is beginning to publish its data. The Urban Institute has also

¹⁸A good summary of these issues can be found in Kimball Lewis, Marilyn Ellwood, and John Czajkas, *Children's Health Insurance: A Review of the Literature* (Washington, D.C.: Department of Health and Human Services, Dec. 17, 1997).

developed and fielded its own health insurance survey. Comparisons of these surveys with the CPS and SIPP may help researchers more definitively agree on the number of uninsured Americans and trends in insurance over time.

**Comparing Estimates of
Medicaid-Eligible Children
Who Are Uninsured**

Using either CPS or new CTS data, five different groups of researchers compared estimates of uninsured Medicaid-eligible children. (See table I.2.) While the number of Medicaid-eligible children and definition of Medicaid eligibility used by the researchers differed, all came up with a similar conclusion—many uninsured children are eligible for Medicaid. The researchers' estimates ranged from 24 to 45 percent.

Table I.2: Estimates of the Number of Uninsured Children Who Are Eligible for Medicaid but Are Uninsured, by Source

Source	Survey	Time period	Age group of Medicaid-eligible uninsured children	Eligibility criteria	Uninsured children eligible for Medicaid	
					Number (in millions)	Percentage of uninsured
Urban Institute's TRIM2 model ^a	CPS, March 1996	1995	Less than 18 years	State-specific poverty-related and AFDC-eligible; SSI children; medically needy children; estimated assets	1.6 ^a	24 ^b
Reschovsky (1997)	CTS	late 1996- early 1997	Less than 19 years	State-specific poverty-related	3.1	35 ^c
Thorpe (1997b)	CPS, March 1996	1995	Less than 19 years	Not given	3.3	31 ^c
GAO (1996)	CPS, March 1995	1994	Less than 12 years	Federal-poverty-related; not state-specific	2.9	30 ^b
GAO (1998)	CPS, March 1997	1996	Less than 13 years	Federal-poverty-related only; not state-specific	3.4	33 ^b
Center on Budget and Policy Priorities (1997)	CPS, March 1995	1994	Less than 11 years	Federal-poverty-related; not state-specific	2.7	45 ^d

^aDecreases estimate of uninsured and increases Medicaid enrollment to adjust for differences between HCFA Medicaid enrollment data and CPS data.

^bEstimate of the percentage of uninsured children less than 18 years old who were Medicaid eligible.

^cEstimate of the percentage of uninsured children less than 19 years old who were Medicaid eligible.

^dEstimate of the percentage of uninsured children less than 11 years old who were Medicaid eligible.

Source: Kimball Lewis, Marilyn Ellwood, and John L. Czajka, *Children's Health Insurance Patterns: A Review of the Literature* (Cambridge, Mass.: Mathematica Policy Research, Inc., 1997).

Nonsampling Error

Since CPS estimates come from a sample, they may differ from figures from a complete census using the same questionnaires, instructions, and enumerators. A sample survey estimate has two possible types of errors: sampling and nonsampling. Each of the studies mentioned above—using either CPS or other sampling surveys—has the same possible errors. The accuracy of an estimate depends on both types of error, but the full extent

of the nonsampling error is unknown. Several sources of nonsampling errors include the following:

- inability to get information about all sample cases;
- definitional difficulties;
- differences in interpretation of questions;
- respondents' inability or unwillingness to provide correct information;
- respondents' inability to recall information;
- errors made in data collection, such as recording and coding data;
- errors made in processing data;
- errors made in estimating values for missing data; and
- failure to represent all units with the sample (undercoverage).¹⁹

¹⁹Bureau of the Census, Current Population Survey, March 1997, Technical Documentation (Washington, D.C.: U.S. Department of Commerce, Bureau of the Census, Economics and Statistics Administration, 1997).

Demographics of Medicaid-Eligible Children Who Are Uninsured

Tables II.1 through II.3 provide a demographic profile of Medicaid-eligible children in 1996.

Table II.1: Number and Percentage of Medicaid-Eligible Children Who Were Insured by Medicaid or Uninsured in 1996, by Race and Ethnicity

	Medicaid		Uninsured	
	Number (in thousands)	Percentage enrolled	Number (in thousands)	Percentage
White	3,175	54.1	1,238	21.1
Black	2,883	69.4 ^a	784	18.9
Hispanic	2,424	58.8	1,205	29.2 ^b
Other, non-Hispanic	465	54.9	217	25.6
Total	8,947	59.7	3,445	23.0

Note: Numbers may not add to totals due to rounding.

^aStatistically different from rate for whites and Hispanics.

^bStatistically different from rate for whites and blacks.

Table II.2: Percentage of Uninsured Medicaid-Eligible Children in 1996, by Race and Ethnicity and by Region

	White, non-Hispanic	Black, non-Hispanic	Hispanic	Other, non-Hispanic	Total	
					Percentage	Number (in thousands)
Northeast	38.0	23.0	30.7	8.3	100	459
Midwest	48.6	32.4	14.4	4.6	100	458
South	37.1	30.6	27.4	4.9	100	1,486
West	27.9	7.2	56.7	8.2	100	1,042
West excluding California	38.8	6.3	47.7	7.2	100	481
California	18.5	8.0	64.4	9.1	100	560
U.S.	36.0	22.8	35.0	6.3	100	3,445

Note: Numbers may not add to totals due to rounding.

Appendix II
Demographics of Medicaid-Eligible Children
Who Are Uninsured

Table II.3: Percentage of Uninsured Medicaid-Eligible Children in 1996, by Parents' Birth Status and Region

	U.S.-born child and parent	U.S.-born child with foreign-born parent	Foreign-born child and parent	Total	
				Percent	Number (in thousands)
Northeast	59.6	30.1	10.2	100	437
Midwest	85.8	9.6	4.5	100	427
South	71.6	19.6	8.1	100	1,394
West	44.1	37.2	18.6	100	927
West excluding California	64.0	23.6	12.3	100	434
California	26.6	49.3	24.2	100	493
U.S.	63.8	24.8	11.0	100	3,185

Note: Table is based on 92 percent of uninsured Medicaid-eligible children whose records matched with those of their parents. Numbers may not add to totals due to rounding.

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